Consent Form for Herbal Consultation

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Disclosure and Inform Form
This form is being given to you to provide information regarding our client/practitioner relationship and to also outline my ethical practices as an herbalist. After reading this you will then be able to make an informed decision as to whether you would like to consult with me regarding your health concerns, and what you personally would like to gain from working together.

The Role of the Herbalist
As an Herbalist, my ultimate goal is to educate and empower you to reach your health goals. To do so we will approach our sessions from a nutritional, lifestyle and Herbal perspective, which is essential to "adaptive" health. My belief is that our body is innately capable of healing itself and with an individualized herbal lifestyle protocol that is properly used; the body can then be supported to return to a healthy, balanced state.

I do not diagnose or directly treat disease. I do however focus on educating you, the client, on how you can personally enhance your body's own innate healing capacity. All client records are confidential and will only be discussed with you unless you specifically request otherwise. I will be glad to share with you any questions or concerns you may have regarding my training, credentials and experience. If I feel that your needs and wishes are beyond my training and expertise I will gladly refer you to another practitioner. I encourage and support any additional consultations you may wish to pursue especially in the diagnosis and treatment of your health condition.

Client Rights and Responsibilities
-Payment is due at the time services are rendered
-Fee: Initial Consultation $180 for a 1-hour and 45 minutes to 2 hour session; Follow up $30 per 30 minutes. Only **cash or check** accepted
-Missed Appointments: except for emergency situation, without 24 hour notice you will be charged a $50 fee
-Formulas and suggested products: These can be purchased at the apothecary at Desert Sage Herbs and either picked up or shipped to you-however please note you are not obligated to do so and may purchase all or any products elsewhere

You have the right to courteous and respectful care. At any time you may choose to no longer follow any or all of the recommendations provided to you as a result of this consultation. You have the right to consult with another practitioner and all records will be provided upon written request.

Herb Safety

As with anything one takes for their health, they must educate themselves. Throughout history and even through modern research, most herbs that are used for healthcare have excellent safety reports. Herb and drug interactions are rare, but possible. Herbs should not be taken during pregnancy or lactation without expert advice. If you should become pregnant while taking herbs, stop taking them until you have seeked out professional advice. For your safety, it is also your responsibility to fully disclose any medications, herbs, and/or supplements you are currently taking so that you can be offered informed advice. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb should be reported to all health professional involved.

If you are scheduled to have surgery or have been prescribed anticoagulatnts, antiepileptic drugs and/or digoxin, it is advisable to stop taking all herbs and supplements at least 72 hours prior.

I _____have read this document and I understand the nature and extent of the client and practitioner relationships. I therefore voluntarily consent to an herbal consultation. I understand that at any time I am free to discontinue service. I understand Brittney Sounart is not a licensed physician and therefore cannot diagnose or treat disease or prescribe medications. I understand that this or any other herbal consultation is not a substitute for regular medical care. I agree to consult with a medical doctor for any serious or life threatening disease either for myself or someone under my guardianship.

It is ok for you to leave a detailed message at:

phone _____

e-mail_____

____(initial) It is ok that a Desert Sage Herb employee other than myself, Brittney Sounart, can access my files and fill my herbal formulas.

Client/Guardian Signature _____Date_____

Practitioner Signature_____Date_____

Health History Intake Form

PERSONAL INFORMATION

Name _____

Date of Birth _____ Age _____

Address: _____

City _____ State _____ Zip Code _____

Phone (day) _____ (evening) _____

Occupation _____

Relationship Status _____

Children (#/ages) _____

NOTE: *This is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Thank you.*

What are the major concerns that have brought you to this office today? _____

_____

_____

_____

When did this begin? _____

_____

Has anything recently changed or become worse? _____

_____

_____

Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom? _____

_____

Are you currently receiving care from any other health professional?
Name _____
What condition(s)? _____
Are you currently taking any medications, prescriptions, supplements or herbs? Yes ◯ No ◯
Please list them: _____

_____

_____

_____

Do you have any infectious diseases that you know of? Yes ◯ No ◯
If yes, please list them: _____

Are you pregnant? Yes ◯ No ◯ If yes, how many months? _____

Do you have any known allergies or sensitivities? If so, please list them:

_____

_____

Is there any reason why you could not take remedies made in alcohol?

_____

Have you ever been hospitalized or had any surgeries? If so, please note date and reason:

_____

_____

_____

FAMILY MEDICAL HISTORY

Please complete this section only for family members with particular health problems.

	AGE(If deceased, age at & cause of death)	**HEALTH PROBLEMS**
Father		
Mother		
Brothers/ Sisters		
Children		
Other close blood relatives		

PERSONAL HEALTH HABITS

Height _____ Current weight _____ Weight 1 year ago _____

Do you smoke?____ How many years? _____ Amount daily _____

Do you drink alcohol?_____ What?_____ Frequency? _____

Do you use recreational drugs?_____What?_____ Frequency? _____

Do you drink coffee? _____ How much? _____ Tea? _____ How much? _____

How much water do you drink daily? _____

Do you exercise regularly? _____ Frequency? _____

Type? _____ Duration? _____

SAMPLE OF DAY'S MENU

Breakfast:_____

Lunch:_____

Dinner: _____

Snacks: _____

Beverages:_____

HEALTH CONCERNS Check off any experienced in the last three months.

SKIN & HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Other_____
- ☐ Poor healing sores
- ☐ Eczema
- ☐ Hair Loss
- ☐ Hives
- ☐ Pimples
- ☐ Change in skin texture

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Spots in front of eyes
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Cold sores
- ☐ Facial pain
- ☐ Sinus congestion
- ☐ Ear infections
- ☐ Other:_____
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Sore throat
- ☐ Grinding teeth
- ☐ Clicking jaw
- ☐ Mucous in throat
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Poor hearing
- ☐ Canker sores
- ☐ Nose bleeds
- ☐ Eye pain
- ☐ Swollen glands
- ☐ Frequent colds

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Cold hands or feet
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Other: _____
- ☐ Chest pain
- ☐ Palpitations

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Shortness of breath without exertion
- ☐ Other: _____
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Asthma
- ☐ Pain on breathing
- ☐ Production of phlegm What color? _____

GASTROINTESTIANAL

- ☐ Nausea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Food cravings
- ☐ Difficulty swallowing
- ☐ Vomiting
- ☐ Stool is small, hard, dry
- ☐ Indigestion
- ☐ Mucous in stools
- ☐ Gas
- ☐ Poor appetite
- ☐ Other: _____
- ☐ Diarrhea
- ☐ Bad breath
- ☐ Heartburn
- ☐ Rectal pain
- ☐ Bloating
- ☐ Food allergies

Number of bowel movements daily _____

Are they ? Loose ☐ Normal ☐ Hard ☐

Do you rely on any of the following for bowel elimination? ◯ Yes ◯ No

- ☐ Enemas
- ☐ Laxatives
- ☐ Purgatives

URINARY

- ☐ Painful urination
- ☐ Urinary urgency
- ☐ Incontinence
- ☐ Difficulty starting/stopping slow
- ☐ Frequent urination
- ☐ Kidney stone
- ☐ Inability to hold urine
- ☐ Other: _____
- ☐ Blood in urine
- ☐ Irregular flow
- ☐ Decreased flow

MUSCULOSKELTEAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Reduced range motion
- ☐ Other: _____
- ☐ Do you see a chiropractor or massage therapist?(name) _____

FEMALE ONLY: REPRODUCTIVE

Age at first menses: _____
Length of cycle: _____
Duration of bleeding: _____

- ☐ Heavy bleeding
- ☐ Pain with intercourse
- ☐ Unusual bleeding
- ☐ Cramps
- ☐ Discharges
- ☐ Irregular cycles
- ☐ Breast lumps
- ☐ Clots

PMS? If yes, what symptoms?_____

_____

_____

Date and result of last pap smear?_____

# of pregnancies _____ # of births _____ # of miscarriages _____

Premature births _____ Abortions _____ Onset of menopause_____

Type of birth control used_____

Any other gynecological problem? _____

_____

MALE ONLY: REPRODUCTIVE

- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Low sperm count
- ☐ Weak urinary stream
- ☐ Prostatitis
- ☐ Elevated PSA levels
- ☐ Wake up to urinate several times a night
- ☐ Erectile dysfunction
- ☐ Testicular Pain
- ☐ Prostate Cancer
- ☐ Other: _____

NEUROPSYCHOLOGICAL

- ☐ Poor sleep
- ☐ Poor memory
- ☐ Irritability
- ☐ High stress levels
- ☐ Difficulty concentrating
- ☐ Loss of balance
- ☐ Numbness
- ☐ Anxiety
- ☐ Migraine
- ☐ "Spacey"/foggy feeling
- ☐ Depression
- ☐ Seizures
- ☐ Headaches
- ☐ Lack of coordination
- ☐ Other: _____

Hours of sleep per 24 hours? _____

GENERAL

- ☐ Fatigue
- ☐ Fevers
- ☐ Excessive thirst
- ☐ Intolerance to heat/cold
- ☐ Chills
- ☐ Sudden energy drops
- ☐ Night sweats
- ☐ Slow metabolism
- ☐ Other:_____

Thank you.

Notes: